CHAPTER I

GENERAL INFORMATION

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GENERAL INFORMATION

INTRODUCTION

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medicaid Program. To provide a better understanding of the Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid recipients.

The manual can also be an effective training tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

SOURCES OF INFORMATION

Recipient Eligibility Verification System (REVS)

A toll-free number is available 24-hours-per-day, seven-days-a-week, to confirm recipient eligibility status. The numbers are:

1-800-884-9730	
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. By entering either the recipient identification number or the Social Security Number and date of birth, the provider receives responses on up to three dates of service per recipient and up to 10 individual recipients per call. Specific instructions on the use of the system are in Exhibit I.1 to this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

786-6273	Richmond Area
1-800-552-8627	All Other Areas

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on State holidays.

The seven-digit Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for recipient eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to recipients, and recipients who have questions about the Medicaid Program should be directed to their local departments of social services. If REVS is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and REVS numbers are for provider use only and should not be given to recipients. Local departments of social services are responsible for supplying information to recipients, and recipients who have questions about the Program should be directed to their local departments of social services.

Transportation Helpline

The Medicaid Transportation Helpline answers questions concerning billing problems, covered transportation, and payments. The Medicaid Transportation Helpline number is:

1-800-358-5050 All areas

The Transportation Helpline is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on State holidays.

Home and Community-Based Care Services Information

Except for billing issues, all questions, including the interpretation of Medicaid policy and procedures, pertaining to home and community-based care services should be directed to the Home and Community-Based Care Section, Department of Medical Assistance Services (DMAS). The telephone number is

(804) 786-1465 All areas

Community-Based Care Services assistance is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on State holidays.

Maternal and Child Health (MCH) Helpline

The MCH Helpline provides information to providers with information on the following:

- Names and/or locations of maternal and infant care coordinator and prenatal care services providers;
- BabyCare and EPSDT eligibility for DMAS and other MCH programs; and

- Answers to questions about the Women, Infants, and Children (WIC), Head Start, and Early Intervention Programs and other community programs for children and prenatal care.

The telephone number is:

1-800-421-7376 All areas

The MCH Helpline is available Monday through Friday, from 8:30 a.m. to 4:30 p.m., except on State holidays.

UPDATES

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

Updates to this manual will be accompanied by an update transmittal memorandum. These updates will have an identifying code and sequential identification numbers assigned for each calendar year, e.g., H 1-92. The transmittal memorandum identifies the new page number(s) to be added and/or the page(s) to be replaced, and it will provide any other pertinent information regarding the update being made.

To be an effective tool, the manual must be properly maintained. Updates should be promptly filed, according to the following procedures:

An Update Control Log has been provided in the back of this manual. The transmittal log numbers run consecutively from 1-44. When an update package is received, put the updated pages in the appropriate place in the manual and enter the release date in the next blank space in the Update Control Log. The release date is the date of issue by DMAS. File the transmittal letter immediately after the Update Control Log. If the Update Control Log indicates missing transmittals, contact DMAS through the HELPLINE number to request copies of these transmittals. (See the section titled "Sources of Information.")

PROGRAM BACKGROUND - LEGAL BASIS

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, or needy children.

The Medicaid Program is a jointly-administered federal/state program which provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

Virginia's Medical Assistance Program (Medicaid) was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The State Plan for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Governor's Advisory Committee on Medicare and Medicaid and the Board of Medical Assistance Services which approves amendments to the State Plan. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

GENERAL SCOPE OF THE PROGRAM

The Medical Assistance Program (Medicaid) is designed to assist eligible recipients in securing medical care within the guidelines of specified State and federal regulations. Medicaid funds access to medically necessary services or procedures for eligible recipients. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, or DMAS professional staff.

Covered Services

The following services are provided, **with limitations**, by the Virginia Medicaid Program:

- AIDS waiver services - Individuals who are HIV+ and symptomatic and meet the criteria for a nursing facility or hospital level of care can be authorized to receive case management, personal care, private duty nursing, and respite care. (Effective 1991)

- "Approved" medical equipment and supplies including ostomy supplies, insulin supplies, hospital beds, breathing machines, and apnea monitors (Effective 1969; Revised 1974, 1991, and 1993)

- BABYCARE - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two (Effective 1988; Revised 1989)

Covered Services (continued)

- Blood glucose monitors and test strips for pregnant women suffering from diabetes and for whom the physician determines that nutritional counseling alone will not be sufficient to ensure a positive pregnancy outcome (Effective July 1, 1993)
- Christian Science sanatoria services (Effective 1969)
- Clinic services (Effective 1969)
- Contraceptive capsules (Norplant) including the insertion and removal (Effective May 1993)
- Contraceptive injections (Depo-Provera) (Effective May 1993)
- Clinical psychology services (Effective 1981)
- Diabetic test strips for recipients under 21 years of age (Effective July 1989)
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) - For individuals under age 21, EPSDT must include the services listed below:
  - Screening services which encompass all of the following services: (Revised 1990)
    - Comprehensive health and developmental history
    - Comprehensive, unclothed physical exam
    - Appropriate immunizations according to age and health history
    - Laboratory tests
    - Health education (Effective 1990)
  - Home health services (Revised 1990)
  - Eyeglasses (Revised 1990)
  - Dental services (Revised 1990)
  - Hearing services (Revised 1990)
  - Inpatient psychiatric services for recipients under age 21 (Effective October 1991)
  - Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above (Effective 1990)
  - Transplant procedures as defined in the section "transplant services" on page 9.

Covered Services (continued)

All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan. Services requiring preauthorization under the State Plan will continue to require preauthorization. For any services not part of the State Plan, preauthorization must be obtained from:

EPSDT Coordinator
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

- Elderly and disabled waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care, and respite care. (Effective 1982; Revised 1989)
- Emergency hospital services (Effective 1969)
- Enteral nutrition (EN) - Coverage is limited to when the nutritional supplement is the sole source form of nutrition except for individuals authorized through the Technology-Assisted or AIDS Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formulae. (Effective September 1, 1993)
- Eye refractions (Effective 1969)
- Family planning services and supplies (Effective 1969)
- Federally-qualified health center services (Effective 1990)
- Home health services (Effective 1969)
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less) (Effective July 1, 1990)
- Inpatient acute care hospital services (Effective 1969)
- Intensive rehabilitation services (Effective 1986)
- Laboratory and radiograph services (Effective 1969)

Covered Services (continued)

- Medically necessary medical supplies and equipment provided under the intensive rehabilitation or home health services programs and through EPSDT or under the technology-assisted or AIDS waiver programs. Medicaid recipients requiring ostomy, dialysis, or oxygen supplies do not have to be receiving services from one of the above programs for coverage of these supplies.

- Mental health and mental retardation services, with limitations, covered under mental health and mental retardation community services (Effective October 1, 1990)

  - Mental Health

    - Intensive in-home services for children and adolescents
    - Therapeutic day treatment for children and adolescents
    - Day treatment/partial hospitalization
    - Psychosocial rehabilitation services
    - Crisis intervention services
    - Case management services

  - Mental Retardation

    - Day health and rehabilitation services
    - Case management services

  - Mental Retardation Waiver Services

    - Residential support services
    - Day support services
    - Habilitation services
    - Therapeutic consultation

- Nurse-midwife services (Effective 1985)

- Nursing facility services (Effective 1969; Revised 1990)

- Occupational therapy (Effective 1969)

- "Organ and disease" panel test procedures for blood chemistry tests (Effective January 1, 1993)

- Outpatient hospital services (Effective 1969)

- Payment of deductible and coinsurance up to the Medicaid limit less any applicable copayments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid (Effective 1969; Revised January 1, 1991)

Covered Services (continued)

- Physical therapy and related rehabilitative services (Effective 1978)
- Physician services (Effective 1969)
- Podiatry services (Effective 1969-1982; Revised 1983)
- Prescribed legend drugs (Effective 1969) including Clozaril (Clozapine) under certain conditions (effective July 25, 1991); growth hormone; Norplant; and total parenteral nutrition (TPN) under certain conditions as a sole source of nutrition. The following are not covered:
  - Agents containing hydroquinone or its derivatives used solely for depigmentation of the skin (Effective April 1, 1993)
  - Agents used to promote fertility (Effective April 1, 1993)
  - Anorexiant drugs for non-institutionalized recipients
    EXCEPTION: These drugs are covered when a statement of medical necessity is provided indicating that the medical indication is to treat attention deficit disorders or narcolepsy. These drugs are not covered to suppress appetite.
  - DESI drugs considered by the FDA to be less than effective (Effective 1982)
    EXCEPTION: Dipyridamole under the brand name Persantine and by generic manufacturers Purepac (7/12/90), Barr (10/3/90), Lederle (2/5/91), and Geneva (4/16/91), is covered when prescribed for the FDA-approved indication: as an adjunct to Coumarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacements.
  - Drugs which have been recalled
  - Expired drugs dispensed after the labeled expiration date of the product (Effective April 1, 1993)
  - Experimental drugs or non-FDA approved drugs
  - OBRA 90 non-rebated drug products - Drugs distributed or manufactured by certain drug manufacturers or labelers that have not agreed to participate in the Federal Drug Rebate Program (Effective April 1, 1991)
  - Topical hair growth products [Effective July 1, 1992]
  - Vaccines for routine immunizations except under EPSDT
- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be preauthorized by the DMAS central office (Effective 1989)
- Psychological testing for persons with mental retardation as part of the evaluation prior to admission to a nursing facility (January 1, 1989)

Covered Services (continued)

- Rehabilitative services (Effective 1990; Revised 1991)
- Renal dialysis clinic services (Effective 1973)
- Routine exams and immunizations for foster care children (EPSDT is not required.) (Effective 1971)
- Rural health clinic services (Effective 1978)
- Screening and baseline mammograms for women over 35 on an annual or biannual basis in accordance with guidelines established by the American Cancer Society (Effective July 1, 1992)
- Services for individuals age 65 and older in institutions for mental diseases (Effective 1969)
- Specialized nursing facility services (Effective 1990)
- Speech-language therapy services (Effective 1969)
- Technology-assisted waiver services - Individuals under the age of 21 who require both a medical device and ongoing medical care to avert death or disability can be authorized to receive private duty nursing and respite care. (Effective 1988; Revised 1989)
- Transplant services: kidney and corneal transplants without age limits (effective September 7, 1989); under EPSDT, liver, heart, and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age (effective July 19, 1993)
- Transportation services related to medical care (Effective 1969)

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services. Examples of such non-covered services are as follows:

- Abortions except when the life or health of the mother is substantially endangered (Effective 1978)
- Acupuncture (Effective 1980)
- Artificial insemination or in vitro fertilization (Effective 1980)
- Autopsy examinations (Effective 1969)

General Exclusions (continued)

- Cosmetic surgery, including post-mastectomy breast reconstruction (Effective 1969)
- Courtesy calls - visits in which no identifiable medical service was rendered (Effective 1969)
- Court-ordered medical examinations and care (including psychiatric and psychological examinations) (Effective 1969)
- Custodial care (Effective 1969)
- Dental services for recipients 21 years of age and over except for limited oral surgery covered and defined by Title XVIII (Medicare) and preauthorized by DMAS for all recipients (Effective 1973)
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration) (Effective 1982)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare) (Effective 1969)
- Experimental medical or surgical procedures (Effective 1969)
- Eyeglass services for recipients age 21 and over (Effective 1982)
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered. (Effective April 1, 1993)
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay (Effective 1973)
- Interpreter services for recipients who are deaf or hard of hearing
- Items or services covered under a workers' compensation law or other payment sources (Effective 1969)
- Meals-on-Wheels or similar food service arrangements and domestic housekeeping services which are unrelated to patient care (Effective 1969)
- Medical care provided by mail or telephone (Effective 1969)

General Exclusions (continued)

- Medical care provided in freestanding psychiatric hospitals (Effective 1969) except through EPSDT
- Non-legend drugs, even if prescribed, are generally a non-covered service (Effective 1969). The following are exceptions to this policy:
  - Insulin
  - Syringes and needles except in nursing facilities
  - Blood glucose monitors and test strips for pregnant women suffering from diabetes and for whom the physician determines that nutritional counseling alone will not be sufficient to ensure a positive pregnancy outcome (Effective July 1, 1993)
  - Diabetic test strips for recipients under age 21 (Effective July 1989)
  - Family planning drugs and supplies
  - Specific therapeutic categories for nursing facility recipients
- Personal comfort items (Effective 1969)
- Physician hospital services for non-covered hospital stays (Effective 1982)
- Preventive medical care - Other than preventive care services provided under EPSDT and screening mammograms, preventive care such as routine physicals and immunizations, well-child examinations, preschool examinations, camp physicals, and work permit examinations are not covered. Routine exams and immunizations for foster children are not excluded when arranged by the appropriate local Department of Social Services. (Effective 1969)
- Procedures prohibited by State or federal statute or regulations (Effective 1969)
- Prostheses, other than limbs and the items necessary for attaching them
- Psychological testing done for purposes of educational diagnosis or school admission or placement (Effective 1971)
- Rehabilitative treatment of substance abuse (Effective 1969)
- Routine foot care (Effective 1983)
- Services determined not to be reasonable and/or medically necessary (Effective 1969)
- Services to persons under age 65 in mental hospitals (except under the EPSDT coverage) (Effective 1969; Revised 1990)

General Exclusions (continued)

- Social behavior modification (Effective 1981)
- Sterilizations when the patient is under age 21 or legally incompetent (Effective 1974)
- Supplies and equipment for personal comfort, such as adult diapers, "Lifecall" systems, and air cleaners
- Transsexual surgery (Effective 1980)
- Unkept or broken appointments (Effective 1969)
- Unoccupied nursing facility beds (effective March 1991) except for therapeutic leave days for nursing facility patients (Effective 1969)
- Weight loss programs

Virginia Medicaid will not reimburse a provider for non-covered services. Prior to the provision of a non-covered service, the provider must inform the recipient that he or she may be billed for the non-covered service. Recipients have been advised that they may be responsible for payment to providers for non-covered services.

In addition, Virginia Medicaid will not reimburse providers for broken appointments, including transportation services arranged by the recipient who is not at the pickup point or declines to get into the vehicle when the provider arrives. Although it is not a requirement, the provider may bill the recipient the customary charge for broken appointments if this is the usual procedure for the general public. The provider cannot bill the recipient for something outside of the usual and customary procedure.

MEDICAL COVERAGE FOR NONRESIDENT ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for nonresident aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid recipients
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are **not** included in the covered services.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of the inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit in the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring Unit is (804) 786-6548. Office hours are 8:15 a.m. - 5:00 p.m., Monday through Friday except State holidays. An answering machine receives after-hours referrals.

Written referrals should be mailed to:

Recipient Monitoring Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

NOTICE OF PROVIDER RESPONSIBILITY

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and **any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.**

EXHIBIT I.1

THE VIRGINIA MEDICAL ASSISTANCE RECIPIENT ELIGIBILITY VERIFICATION SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance Recipient Eligibility Verification System (**REVS**) offers the Medicaid providers twenty-four-hour-a-day, seven-day-a-week access to current recipient data, allowing for reasonable downtime for file update and maintenance. The REVS enhances the current, operator-assisted system and will be at no cost to the provider community. It can be accessed via the 800 WATS number currently in use.

REVS is accessed by using a touch-tone telephone or a rotary telephone with a tone generator. Not only does REVS offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time in making inquiries. Eligibility information for up to 10 recipients can be obtained in one phone call.

The * Star and # Pound keys are used to signify the end of a transmission or to access an operator.

Operators will only be available during normal work hours to respond to inquiries (name identification) that cannot be accommodated by the automated system (such as the identification of newborns).

REVS prompts the caller throughout the inquiry, giving and receiving only essential, pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid recipient eligibility data base.

System downtime will be scheduled during non-peak hours. If the caller dials REVS during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m.	Daily
2:00 a.m. to 6:30 a.m.	Thursday
10:00 p.m. Saturday to 6:00 a.m.	Sunday

HOW TO USE THE SYSTEM

To access REVS, the provider must have an active Medicaid provider number. The provider's eligibility is verified before access to REVS is authorized.

Responses by the caller to REVS are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information prepared before calling:

- Provider Identification Number
- Recipient Medicaid Number or Social Security Number **and** Date of Birth
- From and Thru Date(s) of Service

Refer to Chapter III of this provider manual for further information about the format for the recipient numbers.

A form has been included in this package to assist in accessing the system and to record system responses. Additional copies may be made for subsequent inquiries. The worksheet details the information flow through the Recipient Eligibility Verification System (REVS).

INFORMATION ENTERED BY PROVIDER:

PROVIDER NUMBER - The caller must have an active seven-digit Virginia Medicaid provider number. If the provider number was miskeyed, it can be re-entered three times before the caller is disconnected. *Rotary phone users will be connected with an operator after four system prompts.*

RECIPIENT MEDICAID IDENTIFICATION NUMBER - The caller must have a valid twelve-digit recipient identification number **or** the recipient's nine-digit Social Security Number **and** date of birth in month, day, and year format (e.g., 02 21 54).

If the recipient number is not found initially by the system, the caller can re-enter the recipient number three times before being disconnected, in case there was an entry error. The system will identify a Social Security Number by its length and will prompt the caller for the date of birth.

DATES OF SERVICE - When the recipient identification number is verified, the caller will be asked to enter the **From** date of service. Then the caller will be asked to enter the **Thru** date of service. All dates entered must be in month, day, year (mmddyy) format.

The caller will have the following limits when entering dates of service:

- The **From** and **Thru** dates of service cannot span more than 31 days.
- Future month information is only available in the last week of the current month.
- Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

If the caller does not have the information required by REVS, a name search can be made by the operator. The operator will give the caller the recipient's Medicaid number only. The operator will not be able to return the caller to REVS for further inquiries. It is suggested that name searches be left for the end of the call. Use of Operator Assistance has the following requirements:

- Service available only during business hours
- Limited to three name searches per call
- Must have recipient name and one other ID (SSN or DOB)

Operator assistance drawbacks:

- Does not return caller to REVS
- Slower response
- Limited accessibility
- Limited information

INFORMATION RETURNED BY REVS

When the dates of service have been entered, REVS will verify the information and respond by speaking the first six letters of the last name and the recipient's Medicaid number for confirmation.

Check the recipient's name and recipient's Medicaid identification number against the provider's records. An incorrect Social Security Number could give the caller access to the wrong recipient. If the caller enters an incorrect final digit, REVS will respond with the correct number.

Remain on the line to obtain important recipient information that might affect payment.

REVS will respond with the following applicable information about the recipient:

- Special Indicator Code
- Client Medical Management Information Including Pharmacy/Physician Provider Number
- Medicare Eligibility
- Other Insurance Coverage
- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (See Supplement A of this manual for an explanation of "MEDALLION.")

(Definition of these responses can be found in Chapter III of this provider manual.)

At this point, REVS will prompt the caller for the next action. The caller may ask for additional dates of service on this recipient, or may inquire on another recipient.

The caller may check up to three dates of service for each recipient and inquire on up to 10 recipients per call.

If the caller is using a Social Security Number instead of the recipient ID number, the dates of service will relate to the first ID reported. If the caller wants to check for another ID, he or she must re-enter the Social Security Number and date of service as a separate recipient inquiry to assure correct data for each date of service.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

If the caller needs instruction on using the REVS, **press *7#**, and he or she will be transferred to an operator. This can be done anytime while the system is prompting for information.

If the caller does not have sufficient information to obtain responses from REVS, **press *7#** and he or she will be transferred to an operator.

If the caller is doing a search by recipient name, he or she must also have a correct Social Security Number or date of birth.

If the caller exceeds the allowed number of inquiries per call, the system will give a message, and the line will be disconnected. The caller can break the connection at any time by hanging up.

If the caller waits too long to respond to a system prompt, the call will be disconnected.

Any spoken data can be repeated by pressing ** immediately after the message.

A response, "not eligible," will be given if the recipient is not eligible for all days within the time span entered.

ERROR MESSAGES

PROVIDER IDENTIFICATION NUMBER - If the provider number entered does not contain the correct number of digits, or it is not found in the Virginia Medicaid system, the caller will get an error message, and can retry three times before being disconnected.

If the caller's provider number is not active, he or she will be disconnected. Contact the Provider Enrollment/Certification Unit at DMAS regarding the provider status.

RECIPIENT MEDICAID IDENTIFICATION NUMBER - If the caller enters a recipient identification number, and it does not have the correct number of digits, or it is not found in the Virginia Medicaid system, he or she will get an error message, and can retry three times before being disconnected.

SOCIAL SECURITY NUMBER - If the caller enters a Social Security Number, and it does not have the correct number of digits, or it is not a valid Social Security Number assigned by the Social Security Administration, or the record was not found in the Virginia Medicaid system, he or she will get an error message, and can retry three times before being disconnected.

If the system finds more than one active record with the same Social Security Number for the dates of service entered, the caller will get an error message and will be prompted to enter the next recipient number. The error message will instruct the caller to contact the Eligibility Worker to determine the correct recipient number under which to bill the claim.

The **"multiple records"** response is the only situation in which the Department of Social Services should be contacted to verify the status of an actively-enrolled recipient. Otherwise, contact the recipient if unable to obtain the desired information from REVS.

DATE OF BIRTH - If the caller enters a date of birth, and it is an invalid date, or it is in the future, or it is not in the correct format (mmddyy), or it is not the correct date of birth for the Social Security Number, he or she will get an error message, and can retry three times before being disconnected.

"FROM" DATE OF SERVICE - If the **From** date is invalid, not in the correct format, is in the future, or more than one year in the past, the caller will get an error message, and can retry three times before being disconnected. The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the **#** key prompts the system to continue.

"THRU" DATE OF SERVICE - If the **Thru** date of service entered is invalid, not in the correct format, in the future, or more than one year in the past, the caller will get an error message, and can retry three times before being disconnected.

If the number of days between the **From** and **Thru** dates is more than thirty-one days, the caller will get an error message, and can retry three times before being disconnected.

QUICK GUIDE TO USING VIRGINIA MEDICAID REVS

- HAVE THE VIRGINIA MEDICAID PROVIDER NUMBER READY.
- ASSEMBLE THE RECIPIENT IDENTIFICATION.
  Be sure to have either:
  - A Medicaid identification number or
  - A Social Security Number and date of birth.
- IDENTIFY SERVICE DATES.
  - Make sure they are no more than one-year-old.
  - Make sure the FROM and THRU dates to be inquired do not span more than 31 days.
  - To obtain the most accurate response, inquire on specific service dates.
- CALL UP THE SYSTEM - Use during off-peak hours will increase accessibility (before 8:00 a.m. and after 5:00 p.m.). Use of local numbers will improve access to the toll-free line for long-distance callers.
- KEY IN THE PROVIDER NUMBER. RECIPIENT IDENTIFICATION, AND DATE(S) OF SERVICE WHEN PROMPTED.
- WRITE DOWN THE CONFIRMATION AND INFORMATION PROVIDED.
- CORRECT MISKEYED DATA BY PRESSING ** AND RE-ENTERING THE INFORMATION OR WAIT FOR A SYSTEM PROMPT.

IMPORTANT TELEPHONE NUMBERS

RECIPIENT ELIGIBILITY VERIFICATION Richmond and Surrounding Counties	1-800-884-9730 (804) 965-9732 (804) 965-9733
DMAS HELPLINE Richmond and Surrounding Counties	1-800-552-8627 (804) 786-6273
PROVIDER ENROLLMENT	(804) 786-3346
TCC HELP DESK (system problems)	(804) 965-7646
FORMS ORDERING DESK	(804) 329-4400

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier
of the Local Social Services/Welfare Agency Currently Handling the Case)

COUNTIES

001	Accomack	087	Henrico	177	Spotsylvania
003	Albemarle	089	Henry	179	Stafford
005	Alleghany	091	Highland	181	Surry
007	Amelia	093	Isle of Wight	183	Sussex
009	Amherst	095	James City	185	Tazewell
011	Appomattox	097	King and Queen	187	Warren
013	Arlington	099	King George	191	Washington
015	Augusta	101	King William	193	Westmoreland
017	Bath	103	Lancaster	195	Wise
019	Bedford	105	Lee	197	Wythe
021	Bland	107	Loudoun	199	York
023	Botetourt	109	Louisa		
025	Brunswick	111	Lunenburg		
027	Buchanan	113	Madison		
029	Buckingham	115	Mathews		
031	Campbell	117	Mecklenburg		
033	Caroline	119	Middlesex		
035	Carroll	121	Montgomery		
036	Charles City	125	Nelson		
037	Charlotte	127	New Kent		
041	Chesterfield	131	Northampton		
043	Clarke	133	Northumberland		
045	Craig	135	Nottoway		
047	Culpeper	137	Orange		
049	Cumberland	139	Page		
051	Dickenson	141	Patrick		
053	Dinwiddie	143	Pittsylvania		
057	Essex	145	Powhatan		
059	Fairfax	147	Prince Edward		
061	Fauquier	149	Prince George		
063	Floyd	153	Prince William		
065	Fluvanna	155	Pulaski		
067	Franklin	157	Rappahannock		
069	Frederick	159	Richmond		
071	Giles	161	Roanoke		
073	Gloucester	163	Rockbridge Area		
075	Goochland	165	Rockingham		
077	Grayson	167	Russell		
079	Greene	169	Scott		
081	Greensville	171	Shenandoah		
083	Halifax	173	Smyth		
085	Hanover	175	Southampton		

CITIES

510	Alexandria
515	Bedford
520	Bristol
530	Buena Vista
540	Charlottesville
550	Chesapeake
560	Clifton Forge
570	Colonial Heights
580	Covington
590	Danville
595	Emporia
600	Fairfax
610	Falls Church
620	Franklin
630	Fredericksburg
640	Galax
650	Hampton
660	Harrisonburg
670	Hopewell
678	Lexington
680	Lynchburg
683	Manassas
685	Manassas Park
690	Martinsville
700	Newport News
710	Norfolk
720	Norton
730	Petersburg
735	Poquoson
740	Portsmouth
750	Radford
760	Richmond
770	Roanoke
775	Salem
780	South Boston
790	Staunton
800	Suffolk
810	Virginia Beach
820	Waynesboro
830	Williamsburg
840	Winchester

STATE MENTAL HEALTH FACILITIES

983	Southern Virginia Mental Health Institute
984	Southwestern Virginia Training Center
985	Southeastern State Hospital
986	Northern Virginia Training Center
987	Virginia Treatment Center
988	Northern Virginia Mental Health Institute
989	Southside Virginia Training Center
990	Central Virginia Training Center
991	Western State Hospital
992	Southwestern State Hospital
993	Piedmont State Hospital
994	Eastern State Hospital
995	DeJarnette Sanatorium
996	Hiram Davis Hospital
997	Catawba State Hospital
998	Blue Ridge Sanatorium

VIRGINIA MEDICAID REVS FORM

1. **Information Entered by Provider:** Provider # _____

Recipient Name _____ Recipient ID _____ Not Found ☐
Recipient SSN _____ Not Found ☐ Birth Date _____ Not Found ☐
From Date _____ (MMDDYY) Thru Date _____ (MMDDYY)

Information Received:

Recipient Name _____ Recipient ID _____ Eligible ☐ Not Eligible ☐
Multiple ☐ SSN _____ City/County Code _____ Case Worker _____
Special Indicator Code _____ Restricted to: Physician _____ Pharmacy _____
Medicare Coverage A ☐ B ☐ Other Insurance _____
Spec. Coverage QMB ☐ QMB EXT ☐ QWDI ☐

2. **Information Entered by Provider:**

Recipient Name _____ Recipient ID _____ Not Found ☐
Recipient SSN _____ Not Found ☐ Birth Date _____ Not Found ☐
From Date _____ (MMDDYY) Thru Date _____ (MMDDYY)

Information Received:

Recipient Name _____ Recipient ID _____ Eligible ☐ Not Eligible ☐
Multiple ☐ SSN _____ City/County Code _____ Case Worker _____
Special Indicator Code _____ Restricted to: Physician _____ Pharmacy _____
Medicare Coverage A ☐ B ☐ Other Insurance _____
Spec. Coverage QMB ☐ QMB EXT ☐ QWDI ☐

3. **Information Entered by Provider:**

Recipient Name _____ Recipient ID _____ Not Found ☐
Recipient SSN _____ Not Found ☐ Birth Date _____ Not Found ☐
From Date _____ (MMDDYY) Thru Date _____ (MMDDYY)

Information Received:

Recipient Name _____ Recipient ID _____ Eligible ☐ Not Eligible ☐
Multiple ☐ SSN _____ City/County Code _____ Case Worker _____
Special Indicator Code _____ Restricted to: Physician _____ Pharmacy _____
Medicare Coverage A ☐ B ☐ Other Insurance _____
Spec. Coverage QMB ☐ QMB EXT ☐ QWDI ☐